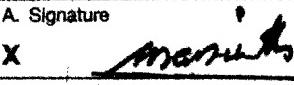
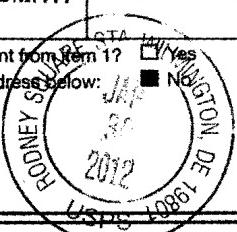


SENDER COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. <input checked="" type="checkbox"/> Print your name and address on the reverse so that we can return the card to you. <input checked="" type="checkbox"/> Attach this card to the back of the mailpiece, or on the front if space permits. 		<p>A. Signature </p> <p><input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Recipient Name MICHAEL A. SMITH</p> <p>C. Date of Delivery STAT</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: Rodney Square North 1100 North Market Street Wilmington, DE 19890-0455</p> <p></p> <p>3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input checked="" type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D. </p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	
<p>1. Article Addressed to: Cincinnati Children's Hospital Medical Center LTD Plan c/o Wilmington Trust Company Attn.: Mr. David Young Rodney Square North 1100 North Market Street Wilmington, DE 19890-0455</p> <p>1/12-cv-80 SAS Rule 4.2</p>		<p>2. Article Number (Transfer from service label) 7009 0080 0001 6714 1000</p>	
PS Form 3811, February 2004		Domestic Return Receipt	
		102595-02-M-1540	